STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155295	A. BUILDING 00 B. WING	05/04/2011

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F0000	This visit was for a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on 3/25/11. This visit was in conjunction with the Investigation of Complaint numbers IN00089874, IN00089459, and IN00089779. Survey dates: May 1, 2, 3, and 4, 2011 Facility number: 000192 Provider number: 155295 AIM number: 100291120 Survey team: Toni Maley, BSW, TC (May 2 and 3, 2011) Donna M. Smith, RN (May 2, 3, and 4, 2011) Tammy Alley, RN (May 2, 3, and 4, 2011) DeAnn Mankell, RN Census bed type: SNF/NF: 55 Total: 55 Census payor type: Medicare: 5 Medicaid: 41 Other: 9 Total: 55	F0000	This plan ofi correctfon is tfhe centfer's credible allegatfon ofi compliance Preparatfon and/or correctfon do notf constftfutfe an admission by tfhe provider ofi tfhe tfrutfh or tfhe fiactfs alleged or conclusion setf fiortfh in tfhe stfatfementf ofi deficiencies. The plan ofi correctfons is prepared and /or excutfed solely because itf is required by tfhe provisions ofi tfhe Stfatfe and Federal law. We are respectfully requestfng a desk review ofi tfhe plan ofi correctfon fior alleged deficiencies	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Sample: 10 These deficiencies also reflect state findings in accordance with 410 IAC 16.2. Quality review completed 5-5-11 Cathy Emswiller RN			

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F0157 SS=D	A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.	F0157	**F157** It is the practice of this facility to promptly notify the residents physician and legal representative or interested family member of changes in condition and plan of care. I.) Resident # L has been assessed by a Licensed Nurse to ensure there were no adverse effects from alleged deficient practice. II.) Residents	05/25/2011

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			with physician orders for blood glucose monitoring have the potential to be affected by the alleged deficient practice. A review of residents currently in house medical record for past 30 days with blood glucose monitoring orders was completed and the physician notified of any previously unreported blood glucose results meeting physician ordered notification parameters. III.) Licensed nursing staff have been re-educated on facility standard of practice for "Notification of Change in Condition" and expectations for notification of physician(s). IV.) The Director of Nursing or designee will review blood glucose monitoring records daily for 4 weeks, then 3 times a week for 4 weeks, then weekly for 4 weeks to ensure results meeting the physician's ordered parameters for notification are reported to the physician. Non-compliance will be addressed through 1:1 re-education and/or progressive disciplinary action as indicated. Results will be reviewed in QA&A meeting monthly for 3 months and then quarterly with a subsequent plan developed and implemented as indicated. ADDENDUM : The Director of Nursing or designee will review blood glucose monitoring records daily for 4 weeks, then 3 times a week for 4 weeks, then weekly for 4 weeks, and monthly times 3	

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	Based on record review and interview, the facility failed to ensure the physician was notified as ordered concerning a blood sugar of less than 60 for 1 of 3 residents reviewed for blood sugars/accuchecks in a sample of 10. (Resident #L) Findings include: 1. Resident #L's record was reviewed on 5/02/11 at 12:15 p.m. The resident's diagnoses included, but were not limited to, dementia and Insulin dependent diabetic mellitus. The physician order, dated 7/31/10, was to notify the physician with an accucheck (blood sugar) result of < (less than) 60 or greater than 350. The physician order, dated 7/29/10, was to check and record blood sugar twice daily. The accuchecks were scheduled for 6 a.m. and 4 p.m. The April, 2011 "INSULIN FLOW RECORD" indicated the Blood Sugar result on 4/30/11 at 6 a.m. was 47 with unclear information concerning the		months to ensure results meeting the physician's ordered parameters for notification are reported to the physician.	

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	"yes/no" information if the physician was notified concerning this blood sugar reading. The 4/30/11 at 6 p.m. accucheck was 62. No further information was indicated in the resident's records concerning the 4/30/11's blood sugars. On 5/03/11 at 10:05 a.m. during an interview, the DON indicated she could not determine on 4/30/11 at 6:00 a.m. on the "INSULIN FLOW RECORD" if the nurse had called the physician for a low blood sugar or not, and she would check on it. On 5/03/11 at 2:20 p.m. during an interview, the DON indicated the physician had not been notified until today concerning the blood sugar of 47 on 4/30/11. At this same time, the DON provided the "CHANGE OF CONDITION REPORT - HYPOGLYCEMIC EPISODE," dated 4/30/11, which indicated the physician had been notified on 5/03/11 at 11:00 a.m. This federal deficiency was cited on 3/25/11. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-5(a)			

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F0272 SS=D	The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. Based on record review and interview, the facility failed to ensure a resident with a low blood sugar was assessed related to a hypoglycemic reaction after a blood sugar	F0272	**F272** It is the practice of this facility to make a comprehensive assessment of a residents need, using the resident assessment instrument (RAI) specified by the	05/25/2011

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	reading of less than 60 was obtained for 1 of 3 residents reviewed for blood sugars/accuchecks in a sample of 10. (Resident #L) Findings include: 1. The "REACTIONS TO INSULIN OR ORAL AGENTS" (revised 06/01/2010) policy was provided by the Nursing Consultant on 5/03/11 at 3:55 p.m. This current policy indicated the following: "Purpose: The purpose of this procedule (sic) is to establish guidelines for hypoglycemic reactions. Procedure ...3) If less than 60, give one of the following: 120 cc (cubic centimeters) Orange Juice to non-renal patient ...4) Repeat accucheck in 15 minutes. If results are still < (less than) 60, repeat #3....." 2. Resident #L's record was reviewed on 5/02/11 at 12:15 p.m. The resident's diagnoses included, but were not limited to, dementia and Insulin dependent diabetic mellitus. The physician order, dated 7/31/10, was to		State, I.) Resident L has been assessed by a Licensed Nurse to ensure there were no adverse effects from alleged deficient practice, and physician has been notified of any change in condition II.) Residents with diagnosis of diabetes who experience hypo/hyperglycemic reactions have the potential to be affected by this alleged deficient practice. A review of residents currently in house with diagnosis of diabetes medical record for last 30 days was completed and the physician has been notified if any change in condition has occurred. III.) Licensed Nurses were re-educated regarding the facility “Change of Condition” standard of practice including assessment of the resident and notification of the physician for change in resident condition. IV.) The Director of Nursing or designee will monitor resident’s medical record for changes in condition and completion of resident assessments 3 times a week for 4 weeks, then weekly for 4 weeks, then monthly thereafter. Non-compliance will be addressed through 1:1 re-education and/or progressive disciplinary actions as indicated. Results will be reviewed in QA&A meeting monthly for 3 months and then quarterly with a subsequent plan developed and implemented as indicated.ADDENDUM:The Director of Nursing or designee	

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	notify the physician with an accucheck result of less than 60 or greater 350. On 5/03/11 at 10:05 a.m. during an interview, the DON indicated she could not determine on 4/30/11 at 6:00 a.m. on the "INSULIN FLOW RECORD" if the nurse had called the physician for a low blood sugar or not, and she would check on it. On 5/03/11 at 2:20 p.m. during an interview, the DON indicated the physician had not been notified until today concerning the blood sugar of 47 on 4/30/11. At this same time, the DON provided the "CHANGE OF CONDITION REPORT - HYPOGLYCEMIC EPISODE," dated 4/30/11. This report indicated no recheck of a blood sugar on 4/30/11 until 6:00 p.m., which was 62. The resident's "Meal intake During this time-frame" was indicated from 50 % to 75%. No further information was indicated related to an assessment of the resident's condition during this low blood sugar reading on 4/30/11 on this form. No further information was indicated concerning an assessment/evaluation of the 4/30/11 at 6 a.m. blood sugar in the resident's record.		will monitor resident's medical record for changes in condition and completion of resident assessments 3 times a week for 4 weeks, then weekly for 4 weeks, then monthly times 4 months to ensure compliance.	

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	This federal deficiency relates to Complaint #IN00089874 and/or IN00089879. 3.1-31(c)(3)			
F0282 SS=D	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on record review and interview, the facility failed to administer medications, including insulin, on the day a resident was readmitted to the facility for 1 of 4 residents readmitted to the facility in a sample of 13 (Resident G). Findings included: 1. Resident G's closed clinical record was reviewed on 5/2/11 at 10:34 A.M. Resident G's diagnoses included, but were not limited to, agitation, depression, atrial fibrillation, hypertension, diabetes mellitus, coronary artery disease, and gastroesophageal reflux disease. Resident G returned from the hospital on 4/15/2011 at 12:30 P.M.	F0282	**F282** It is the practice of this facility to provide qualified persons in accordance with each resident's written plan of care. I.) Resident G no longer resides in this facility. II.) Residents with physician orders for medication and/or glucose monitoring have the potential to be affected by this alleged deficient practice. A review of current in house residents' medication and treatment administration records has been completed to identify any missing medications or treatments and physicians notified as applicable. Licensed nurses have been re-educated on facility expectations for administering medications/ ordering medications, and performing blood glucose monitoring as ordered by the physician. The Director of Nursing or designee will review blood glucose monitoring records,	05/25/2011

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	Resident G's April 2011 MAR (medication administration record) for 4/15/2011 indicated Resident G's 4 P.M. Accucheck was not completed. Resident G's April 2011 MAR (medication administration record) for 4/15/2011 indicated the following medications were not given: "Remeron (antidepressant) 15 mg (milligrams). Give 1/2 tablet (7.5 mg.) orally daily at bedtime." "Lanoxin (strengthen and regulate heart rate) 0.25mg. Give 1 tablet orally daily at bedtime only." "Kepra (anti-seizure medication) 500 mg tablet. Give 1 tablet orally every 12. (Scheduled for 9:00 P.M." "Potassium ER 10 MEQ (milliequivalents) bid. (Scheduled for 5 P.M.)" During an interview with the DON (director of nurses) on 5/4/11 at 10:50 A.M., she indicated she did not know why the accucheck was not done and the medications not given. This federal tag relates to complaint IN00089779. 3.1-35(g)(2)		medication and treatment administration records daily for 4 weeks, then 3 times a week for 4 weeks, then weekly for 4 weeks to ensure glucose monitoring and medications are administered as ordered blood glucose monitoring results meeting the physician's ordered parameters for notification are reported to the physician. Non-compliance will be addressed through 1:1 re-education and/or progressive disciplinary actions as indicated. Results will be reviewed in monthly QA&A meeting for 3 months and then quarterly with a subsequent plan developed and implemented as indicated. ADDENDUM: The Director of Nursing or designee will review blood glucose monitoring records, medication and treatment administration records daily for 4 weeks, then 3 times a week for 4 weeks, then weekly for 4 weeks, then monthly times 3 months. to ensure glucose monitoring and medications are administered as ordered blood glucose monitoring results meeting the physician's ordered parameters for notification are reported to the physician.	

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F0314 SS=D	Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.	F0314	**F314** It is the practice of this facility to ensure that a resident with a pressure sore have the necessary treatment and services to promote healing, prevent infection and prevent new pressure sores. I.) Resident J has been assessed to ensure no adverse affects have been identified due to the alleged deficient practice. II.) Residents who are being treated for open area have been assessed for any adverse reaction and physician notified of any changes in condition. III.) Physical Therapy and Licensed Nurses have been re-educated on proper technique for performing clean dressing changes and timely implementation of interventions for prevention of skin breakdown. IV.) The Director of Staff Development or designee will observe one Physical Therapy/Licensed Nurse performance of clean dressing change weekly for 4 weeks, then monthly for 2 months. The	05/25/2011

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	Based on observations, record review, and interview, the facility failed to ensure a dressing change was completed in a manner to prevent the potential for infections for 1 of 1 resident (Resident #J) whose dressing change was observed and failed to ensure preventive measures were implemented timely to prevent further possible skin breakdown for 1 of 1		Director of Nursing or designee will review treatment administration records daily for 4 weeks, then 3 times a week for 4 weeks, then weekly for 4 weeks to ensure treatments are administered as ordered. Non-compliance will be addressed through 1:1 re-education and/or progressive disciplinary actions as indicated. Results will be reviewed in monthly QA&A meeting for 3 months and then quarterly with a subsequent plan developed and implemented as indicated. ADDENDUM: The Director of Staff Development or designee will observe one Physical Therapy/Licensed Nurse performance of clean dressing change weekly for 4 weeks, then monthly for 5 months. The Director of Nursing or designee will review treatment administration records daily for 4 weeks, then 3 times a week for 4 weeks, then weekly for 4 weeks, then monthly times 3 months, to ensure treatments are administered as ordered.	

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	resident (Resident #L) observed in a sample of 10. Findings include: 1. The "Hand Washing" policy was provided by the Director Of Nursing (DON) on 5/3/11 at 12:40 p.m. This current policy indicated the following: "...PURPOSE * Medical asepsis to control infection. * To reduce transmission of organisms from resident to resident. * To reduce transmission of organisms from nursing staff to resident. * To reduce transmission of organisms from resident to nursing staff. ...PROCEDURE* ...7. Rub hands briskly using sufficient lather and friction for ten to fifteen seconds,...." The "Dressing Change, Clean" policy was provided by the DON on 5/03/11 at 12:40 p.m. This current policy indicated the following: ...PURPOSE * To protect wound. * To prevent infection. * To prevent infection and spread of infection.			

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	* To promote healing. ...PROCEDURE ...6. Remove soiled dressing and discard in plastic bag. 7. Dispose of gloves in plastic bag. 8. Put on second pair of disposable gloves. The handwashing audit was provided by the Nursing Consultant on 5/03/11 at 3:55 p.m. This current audit indicated the following: "...Soap hands. Use friction to clean hands. Silently sing one verse of happy birthday. ...Quiz: When should you wash your hands? Answer: ...After all direct contact with residents involving contact with skin or body fluids. After glove use....." 2. On 5/03/11 from 9:10 a.m. to 9:40 a.m., Resident #J's right gluteal dressing change was observed. After obtaining her supplies, including a debridement kit, Physical Therapist (PT) #3 was observed to handwash for less than 10 seconds. After opening the debridement kit on the bedside table, she donned a pair of gloves and removed the soiled dressing, The			

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	soiled dressing was observed wet with a grayish colored drainage on the dressing. At this same time during an interview, PT #3 indicated the odor now present was not as bad as yesterday, and she indicated the odor was probably from the necrotic tissue. With the same gloves, PT #3 then proceeded to place her gloved finger inside the open area as she checked the wound's tunneling. The surrounding area of the open area was observed to be bright red in color. After removing her gloves and donning a new pair, PT #3 debrided a small to moderate amount of dark yellow to yellow substance from the wound. After PT #3 indicated she had completed the wound debridement, she placed the soiled scaple and tweezers on the paper beside the blue tray of the debridement kit. She then cleansed the open area with the same gloved hands and a piece of gauze 2 different times. Next, as she prepared to measure the open area, she removed her right hand glove, retrieved a pen from her pocket, and then, donned a new glove to the right hand. Next, she measured the open area with a paper measuring tape and Q-tip. With a second Q-tip and the same gloves, she swabbed the open necrotic area with Sanytl mixture, used the debridement tweezers to pack the open area, and covered it with the border gauze. After she removed her gloves, she used the retrieved pen to mark			

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	155295	A. BUILDING 00 B. WING	05/04/2011

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	the date and initials on the dressing. After cleaning up the area, she was observed to handwash for 12 seconds. At this same time during an interview, PT #3 indicated one should handwash for the length of time it took to recite one's ABC's. On 5/04/11 at 8:25 a.m. during an interview, PT #3 indicated due to Resident #J's skin surrounding the open area was so red, she indicated the dressing should probably be changed more often. She indicated one could not be sure if the dressing became wet just from the wound drainage or due to the resident's incontinence. Resident #J's record was reviewed on 5/02/11 at 3:20 p.m. The resident's diagnoses included, but were not limited to, sacral decub ulcer. The physician order, dated 4/13/11, was wound care clarification to continue Santyl and polysporin powder on wound and cover with border gauze. Physical therapy was to do wound care on Monday through Friday, and nursing was to do it on Saturday and Sunday. The Braden Scale score, dated 4/13/11, was 13 with a total score of 12 or less represented a high risk.			

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	The "PRESSURE ULCER EVALUATION RECORD" indicated the following: On 4/05/11 the Stage II right gluteal area measured 1 cm in length by 1.1 cm. width and 0.1 cm depth with serosanguineous drainage and granulating with light drainage. On 4/25/11 the right buttock measured 3 centimeters (cm) length by 2.5 cm width by 0.1 cm depth with 1 cm of tunneling at the 9 o'clock, 12 o'clock, and 3 o'clock locations. Serous with 100% slough was indicated with poor progress noted. On 5/02/11 the right buttock measured 3 cm length by 2 cm width by 1.6 cm depth with serous drainage indicated and 55% slough with improvement noted. No tunneling information was indicated. The "PRESSURE ULCER LOG," dated 5/02/11, indicated depth at 12 o'clock was 12, 1.5 cm at 3 o'clock, 1.5 cm at 6 o'clock, and 1.5 cm at 9 o'clock. 3. On 5/01/11 at 10:55 p.m., Resident #L's personal care was observed. As CNA #4 removed the resident's brief, she indicated he had been incontinent of urine. Also, the resident's bottom sheet and sheet for repositioning were also observed wet from urine. During his personal care, the resident's left buttock			

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	was observed with a 2 centimeter (cm) by 3 cm. sized oblonged dark red area. After his care was completed, a new brief was only applied, and the resident was repositioned in his bed. On 5/01/11 at 11:15 p.m. during an interview with LPN #5, she indicated Granulex had been ordered for his buttocks, and she did not have any as his insurance would not pay for it. She indicated barrier cream should had been applied, and she would go back in and put on the barrier cream due to the cream was not applied by the CNA during personal care. On 5/02/11 at 10:10 a.m. during an interview, LPN #1 indicated Resident #L's treatment for his buttock had not been given last night as scheduled. She indicated she would have to check with the physician due to she thought the treatment ordered was not covered by the resident's insurance. On 5/02/11 from 3:55 p.m. to 4:10 p.m., Resident #L's personal care was observed. At this same time during an interview, CNA #2 indicated the resident had been incontinent of urine and was always incontinent of urine. Resident #L was observed with a white layer of cream over his buttocks with a oblonged shaped 2 inch sized abrasive-like area observed on the left buttock area near the rectal area. The resident's personal care was completed without removing any of the cream on the resident's buttocks as CNA #2 indicated she			

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	did not want to wash his cream off. Resident #L's record was reviewed on 5/02/11 at 12:15 p.m. The resident's diagnoses included, but were not limited to, dementia, Insulin dependent diabetic mellitus, and depression. The resident required extensive assistance of 1 to 2 persons for activities of daily living and was incontinent of bowel and bladder. The faxed transmission on 4/29/11 was a request for a treatment "before if (sic) worsens" for a "Stage I areas to B (in a circle) (bilateral) buttocks." The physician order was Granulex daily for 14 days. The faxed transmission on 4/30/11 was a request for a different treatment as Granulex was not covered by his insurance. The physician had requested information concerning what treatment would be covered. The answer was returned on 5/02/11 requesting A & D ointment (barrier cream) every shift for 10 days. The physician order, dated 5/03/11, was to discontinue the A & D ointment and to start Desitin (skin protectant) to reddened area on buttocks 1 time a day for 14 days. The "NON-PRESSURE SKIN CONDITION REPORT" indicated the following: On 4/19/11, the "buttocks gluteal fold" and "back of scrotum" with the area measuring 2.5 cm (centimeter) length by 1 cm width by 0.1 cm depth The condition was indicated as "excoriation" and "denuded" with a pink/beefy red wound bed. On 4/25/11, the pink/beefy red wound bed measured 2 cm length by 1 cm width and 0.1 cm depth.			

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	On 5/04/11, the pink/beefy red wound bed measured 2 cm length by 1 cm width with the skin intact. This federal deficiency was cited on 3/25/11. The facility failed to implement a systemic plan of correction to prevent recurrence. This federal deficiency relates to Complaint #IN00089874. 3.1-40(a)(2)			
F0425 SS=D	The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on record review, observation and interview, the facility failed to ensure medications were available for administration for 2 of 10 residents reviewed for medication availability in a	F0425	**F425** It is the practice of this facility to employ or obtain the services of a licensed pharmacist who provides consultation of pharmacy services in the facility. I.) Residents I and L have been	05/25/2011

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	sample of 10. (Resident #'s I and L) Findings include: 1. The record for Resident I was reviewed on 5/2/11 at 2:48 p.m. A 4/4/11 laboratory test indicated the resident was positive for Clostridium Difficile Toxin (C-Diff). A physician order dated 4/5/11 indicated an order for Vancomycin (antibiotic) 125 milligrams three times daily for 7 days, then twice daily for 7 days, then once daily for 7 days. The April 2011 Medication Administration Record (MAR) indicated the Vancomycin was not given on 4/24-26/11. The back of the MAR indicated on 4/24/11 the Vancomycin was outdated and on 4/25/11 the MAR indicated the Vancomycin was not in the Emergency Drug Kit and the pharmacy was notified. There was not explanation why the Vancomycin was not given on 4/27/11. A physician order dated 4/27/11 indicated an order for the Vancomycin to be given for 7 more days to replace the missed doses due to the supply had expired.		assessed to ensure there have been no adverse effects due to the alleged deficient practice. II.) Residents who received medications through the contracted pharmacy have the potential to be affected. A reconciliation of current in house residents physician's orders and medication availability has been completed. Medications or treatments not available, if any, have been ordered and the physician has been notified. Administrator has made contact with contracted pharmacy, requesting the pharmacy send a 3 day supply of any medication or treatment not covered by insurance, allowing time to contact the doctor for new orders if needed. III.) Nursing staff has been re-educated on facility procedure for ordering medications/ treatments and directed to contact the Director of Nursing or Administrator if medications/treatments are not available in a timely manner. The Director of Nursing or designee will review medication and treatment administration records daily for 4 weeks, then 3 times a week for 4 weeks, then weekly for 4 weeks to ensure medications/treatments are available for administration as ordered. Non-compliance will be addressed through 1:1 re-education and/or progressive disciplinary actions as indicated. Results will be reviewed in QA&A	

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	During an interview with the Director of Nursing on 5/3/11 at 9:40 a.m., she indicated 3 doses of the Vancomycin were not given. 2. On 5/01/11 at 10:55 p.m. and on 5.02/11 at 3:55 p.m., Resident #L's personal care was observed. During these care observations, the resident's left buttock was observed with a 2 centimeter (cm) by 3 cm. sized oblonged dark red area. On 5/01/11 at 11:15 p.m. during an interview with LPN #5, she indicated Granulex had been ordered for his buttocks. She indicated she did not have any Granulex due to his insurance would not pay for it. She indicated barrier cream was being used presently. On 5/02/11 at 10:10 a.m. during an interview, LPN #1 indicated Resident #L's treatment for his buttock had not been given last night (5/01/11) as scheduled. She indicated she would have to check with the physician due to she thought the		meeting monthly for 3 months and then quarterly with a subsequent plan developed and implemented as indicated. ADDENDUM: The Director of Nursing or designee will review medication and treatment administration records daily for 4 weeks, then 3 times a week for 4 weeks, then weekly for 4 weeks, then monthly times 3 months, to ensure medications/treatments are available for administration as ordered.	

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	treatment ordered was not covered by the resident's insurance. Resident #L's record was reviewed on 5/02/11 at 12:15 p.m. The resident's diagnoses included, but were not limited to, dementia, Insulin dependent diabetic mellitus, and depression. The faxed transmission on 4/29/11 was a request for a treatment "before if (sic) worsens" for a "Stage I areas to B (in a circle) (bilateral) buttocks." The physician order was Granulex daily for 14 days. The faxed transmission on 4/30/11 was a request for a different treatment as Granulex was not covered by his insurance. The physician had requested information concerning what treatment would be covered. The answer was returned on 5/02/11 requesting A & D ointment (barrier cream) every shift for 10 days. The physician order, dated 5/03/11, was to discontinue the A & D ointment and to start Desitin (skin protectant) to reddened area on buttocks 1 time a day for 14 days. The 4/2011 medication/treatment record indicated Granulex had not been given on 4/29 or 4/30/11 as ordered. No reason was indicated on this record. This federal deficiency was cited on 3/25/11. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-25(a)			

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